

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County WicomicoCity or town Nanticoke  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 69 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary E. Baylton

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife John Baylton6. (c) If alive, give age 75 years7. Birth date of deceased (mo., day, yr.) Aug 15, 18818. AGE: Years 69 Months 2 Days 5 If less than one day  
hrs. min.9. Birthplace Nanticoke, Wicomico, Md.  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name William Wallace13. Birthplace Maryland14. Maiden name Katie Miller15. Birthplace Maryland16. Informant John BayltonAddress Nanticoke, Md.17. Burial Date thereof Oct 24, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Nanticoke CemeteryLocation Nanticoke, Md.18. Funeral director Wilson's Funeral HomeAddress Princess Anne Md.October 23, 1948 Loise Strong Taylor  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Nanticoke  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1948, at 1<sup>05</sup> A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 April 1947, to 20 October 1948and that I last saw him alive on 20 October 1948Immediate cause of death Cerebral Hemorrhage

DURATION

3 weeksDue to Arterio-sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

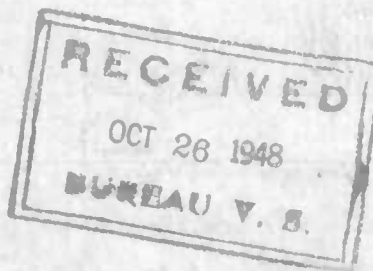
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Donald H. Saunders MD.

M. D. or other

Address Nanticoke Md. Date signed 20 Oct 48

Bryton



Dr. Rock

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10862

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County McComickCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 1/2 monthsHospital, institution, or street address where death occurred:  
U.S. Army.How long in hospital or institution? 7 days 6 hrs. 45 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County PhiladelphiaCity or town Philadelphia  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2970 Richmond street  
(If rural, give LOCATION)2. (a) If veteran, name war ☒

## 3. (a) FULL NAME

Elizabeth Basziah

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anthony Basziah6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.)

Feb. 5 - 1888

8. AGE:

Years

60

Months

8

Days

5

If less than one day

hrs.

min.

9. Birthplace

Poland  
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

at home

FATHER

12. Name

Peter Costra

13. Birthplace

Poland

MOTHER

14. Maiden name

Anna Rojewska

15. Birthplace

Poland

16. Informant

Mr. Lena Prydore

Address

509 S. Park Drive, Salisbury, Md.

17. Burial

(Burial, cremation, or removal) Which?

Date thereof

Oct. 14 - 48

Cemetery or crematory

McComick Mem. Park

Location

Salisbury, Maryland

18. Funeral director

William G. Walter R. Hollomay

Address

Salisbury, Md.19. 10-13 -  
(Date rec'd by registrar)19. 48Mary W. Hollomay  
Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 10<sup>th</sup> 1948 at 48 8:30 p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 1948 to Oct 10 1948and that I last saw him alive on Oct 10/48

Immediate cause of death

Circumstances of death

Due to

Circumstances of death

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

W.R.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Webb

M. D. or other

Address

Salisbury

Date signed

10/15/48

MARGIN RESERVED FOR BINDING

9-45-15M

S A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH  
 County Hebron  
 City or town Hebron  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
R.O. #1  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md. County Hebron  
 City or town Hebron  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.O. #1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME Ernest Wildie Bennett 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Agnes Emily Bennett  
 7. Birth date of deceased (mo., day, yr.) Aug. 12-1874 8.(c) If alive, give age 66 years  
 8. AGE: Years 74 Months 1 Days 26 It less than one day hrs. min.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH Oct. 8<sup>th</sup> 1948 at 9-P P.M.  
 I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30<sup>th</sup> 1948 to October 8<sup>th</sup> 1948  
 and that I last saw him alive on October 8<sup>th</sup> 1948  
 Immediate cause of death Cerebral Hemorrhage  
 Due to  
 Due to  
 Other conditions Arteriosclerosis  
 (Include pregnancy within 8 months of death)

9. Birthplace Mardela Maryland  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Own Farm  
 12. Name William Bennett  
 13. Birthplace Mardela Maryland  
 14. Maiden name Elizabeth Riggan  
 15. Birthplace Mardela Maryland  
 16. Informant Mrs. Agnes J. Bennett  
 Address R.O. #1 Hebron Maryland  
 17. Burial Date thereof Oct. 11-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Mardela Cemetery  
 Location Mardela Maryland  
 18. Funeral director Hollman & G. Walter R. Hollman  
 Address Hebron Maryland  
 19. Oct-11-48 Marj W. Hollman Registrar  
 (Date rec'd by registrar)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, pub'c place (where?)  
 Injured at work?  
 23. SIGNATURE William E. Enrich M. D. or other  
 Address Hebron Md. Date signed Oct. 9-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

10865

## 1. PLACE OF DEATH:

County *Wicomico*City or town *Salisbury*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*154. Penna. Ave.*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Wicomico*City or town *Salisbury*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *154. Penna. Ave.*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*Bounds - James Edward*

## 3. (b) Social Security Number

4. Sex

*Male*

5. Color or race

*White*

6. (a) Single, married, widowed, or divorced

*Widower*

B. (b) Name of husband or wife

*Annie L. Bounds*B. (c) If alive, give age *Dead* years

7. Birth date of

deceased (mo., day, yr.)

*Aug. 15. 1871*

8. AGE:

Years

Months

Days

If less than one day

*77**1**18*

hrs.

min.

9. Birthplace

*Silvane Md.*  
(Town, county, and state)

10. Usual occupation

*Retired*

11. Industry or business

*Restaurant Prop.*

12. Name

*William H. Bounds*

13. Birthplace

*Silvane Md.*

14. Maiden name

*Maranda Culver*

15. Birthplace

*Silvane Md.*

16. Informant

*Mr. Howard C. Bounds*

Address

*137. Penna. Ave. Salisbury Md.*

17.

*Buried*

Date thereof

*Oct. 6-48*  
(month) (day) (year)

Cemetery or crematory

*Silvane Cemetery*

Location

*Silvane Md.*

18. Funeral director

*William C. Galt R. Wilcox*

Address

*Salisbury Md.*

19.

*Oct-4*

19.

*48*

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Oct. 3-48* at *3.9 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Feb. 19.47* to *Oct 3; 19.48*and that I last saw him alive on *Oct 1 19.48*

Immediate cause of death

*acute cardiac failure*

DURATION

Due to

*arteriosclerotic heart*

Due to

*diarrhea -*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Lucretia Taylor*

M. D. or other

Address

*Salisbury Md.*Date signed *10-4-48*





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

10866

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

38 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 226 E. 1st Street  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Bozman, Mrs. John

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced ✓6. (b) Name of husband or wife May Boyman7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1875 6. (c) If alive, give age 65 years8. AGE: Years 73 Months 8 Days 10 It less than one day hrs. min.9. Birthplace Somerset Co. Maryland  
(Town, county, and state)10. Usual occupation Retiree

11. Industry or business

12. Name Henry H. Boyman13. Birthplace Somerset Co. Maryland14. Maiden name Sallie Ann Boyman15. Birthplace Somerset Co. Maryland16. Informant Mrs. May BoymanAddress 226 E. 1st St. Salisbury Md.17. Burial Oct. 26 - 1948 Date thereof (month) (day) (year)Cemetery or crematory McComie Mem. ParkLocation Salisbury Maryland18. Funeral director John W. C. Miller R. HollenbeckAddress Salisbury Maryland19. Oct-26-48 19 48 Loise Strong Taylor Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 19 48 at 1277 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 48 to Oct 24 19 48and that I last saw him alive on Oct 24 19 48Immediate cause of death UremiaDue to Chronic nephritis anduricemia by pathologic process

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theresa E. Taylor M. D. or otherAddress Salisbury Md. Date signed 10-25-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 29 1948  
BUREAU A. S.

Dr. Lewis

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10867

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County McCombeCity or town Powellville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County McCombeCity or town Powellville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Elmer Powell Burtage

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Oct. 17<sup>th</sup> 1948 at 10:25 P. M.

## 6. (b) Name of husband or wife

Halter B. Burtage

7. Birth date of deceased (mo., day, yr.)

Nov. 10-1882

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

65117

hrs.

min.

## 9. Birthplace

Powellville Md.

(Town, county, and state)

## 10. Usual occupation

Worker at

## 11. Industry or business

Saw mill

## FATHER

12. Name

Hiram Burtage

13. Birthplace

Powellville Md.

## MOTHER

14. Maiden name

Laura A. Powell

15. Birthplace

Powellville Md.

## 16. Informant

Wm. William H. Burtage

Address

Sum Hill Maryland

## 17. Burial

Oct. 20-48

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

St. John's Cemetery

## Location

Powellville Md.

## 18. Funeral Director

Hillman & G. Walter R. Hillman

Address

Salisbury Md.

## 19.

October 19 1948

(Date rec'd by registrar)

Registrar

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1, 1948 19. 10-17-48 19.and that I last saw him alive on 10-17-48 19.

## Immediate cause of death

Leukemia acute

## DURATION

6 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Frank R. Lewis M.D.

M. D. or other

Address

Willards Md.Date signed 10-18-48

74a

332

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 21 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10868

## CERTIFICATE OF DEATH

Reg. Diat. No. 332

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 days 11 1/2 hours  
 Hospital, institution, or street address where death occurred:  
Penninsula General Hospital  
 How long in hospital or institution? 21 days 11 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Wicomico  
 City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no (If rural, give LOCATION) no  
 2.(a) If veteran, name war no ✓

## 3. (a) FULL NAME

Paul Cherry

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Frances Cherry  
yes 6. (c) If alive, give age 43 years  
 7. Birth date of deceased (mo., day, yr.) 1905  
 8. AGE: Years 43 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Edenton N.C.  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business Same as above  
 12. Name Edward Cherry  
 13. Birthplace Edenton N.C.  
 14. Maiden name Sanzie Mahan  
 15. Birthplace N.C.

16. Informant Mary Cherry  
 Address Berlin md  
 17. Burial Date thereof Nov 3-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Evergreen  
 Location Berlin md

18. Funeral director James H. Stewart  
 Address Salisbury md  
 19. Nov-1 1948 Louise Strong Taylor  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1948 at 6:30 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-8 1948 to act 30 1948  
 and that I last saw him alive on act 28 1948  
 Immediate cause of death acute nephritis  
& pyelonephritis  
 DURATION 3 weeks  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Enlarged Kidneys  
ascites Date of op. 10/21/48  
 Autopsy results non  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; N  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE L. Rademaker M. D.  
Salisbury, md M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 11/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
NOV 3 1948  
BUREAU A. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 11

10869

336

932

## 1. PLACE OF DEATH:

County Wicomico  
City or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 weeks  
Hospital, institution, or street address where death occurred:607 East Chestnut Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline  
City or town Federalburg - Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Preston Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elmer R. Cole

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 30<sup>th</sup> 1948, at 11<sup>40</sup> A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 27<sup>th</sup> 1948 to October 30<sup>th</sup> 1948  
and that I last saw him alive on October 29<sup>th</sup> 1948Immediate cause of death Pneumonia, hypostatic DURATION 3 days

Due to

Due to

Other conditions arteriosclerotic heart disease, auricular fibrillation  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

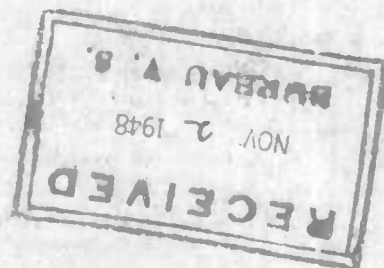
23. SIGNATURE L.V. Solter, M.D. M.D. or otherAddress Delmar Md. Date signed 10-30-486. (b) Name of husband or wife Linda Cole7. Birth date of deceased (mo., day, yr.) March 30, 18758. AGE: Years 73 Months 7 Days 0 If less than one day  
.....hre. ....min.9. Birthplace Caroline County, Maryland  
(Town, county and state)10. Usual occupation Retired Farmer11. Industry or business Farm12. Name John F. Cole13. Birthplace Caroline County, Maryland14. Maiden name Louderland15. Birthplace Caroline County, Maryland18. Informant Elmer J. ColeAddress Federalburg, Maryland, R.F.D.17. Burial Date thereof Nov. 2, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory West Crest CountryLocation Federalburg, Maryland18. Funeral director J. J. Thompson, DelmarAddress Federalburg, MarylandOctober 30, 1948 Registrar

(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correction is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10870

## CERTIFICATE OF DEATH

Reg. Diat. No. 332

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs.Hospital, institution, or street address where death occurred: Parsons HomeHow long in hospital or institution? ✓

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Robert J. Dryden

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

78220

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal? Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

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## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 3

19.

48 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July1946Oct 3, 1948and that I last saw her alive onOct. 3

19.

48

Immediate cause of death

Respiratory failure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert R. Starr

M. D. or other

Address

Salisbury

Date signed

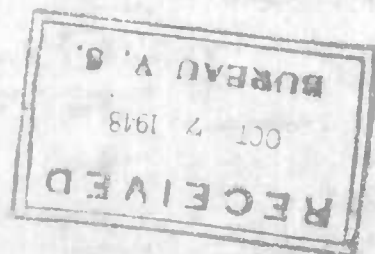
10-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rob.  
Storr  
N. Director



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

10871

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 hrs - 50 min.  
 Hospital, institution, or street address where death occurred:  
Penninsula General Hospital  
 How long in hospital or institution? 7 hours 50 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Pocomoke City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 208 6th St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

Rosa A. Duncan

## 3. (b) Social Security Number

?

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 7 - 1895

8. AGE: Years 53 Months 7 Days 3 If less than one day  
 hrs. min.

9. Birthplace Miona Accomac Virginia  
 (Town, county, and state)

10. Usual occupation Secretary and Treasurer

11. Industry or business Duncan Brothers Inc.

12. Name William B. Duncan

13. Birthplace Virginia

14. Maiden name Bloume Taylor

15. Birthplace Virginia

16. Informant Lywood W. Duncan

Address Pocomoke City Md.

17. Burial Date thereof Oct 12, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hells Hill Baptist Cemetery

Location Pocomoke Md.

18. Funeral director Henry A. Watson

Address Pocomoke Md.

19. 10-12 - 48 Mary W. Holloman  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1948 at 2:00 PM

21. I CERTIFY that death occurred on the date above stated; that I last saw the deceased on Oct 9th at 11 PM

and that I last saw him alive on Oct 9th at 11 PM

Immediate cause of death Diffuse Brain Damage

Due to Fractured Skull

Due to Fall

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Oct 9th

Where did injury occur? Pocomoke City (City or town) Worcester (County) Md (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury Fall Injured at work? No

23. SIGNATURE N. E. Cartwright Jr Md

Address Pocomoke City Md Date signed 10/10/48

10-12 - 48 Mary W. Holloman  
 (Date rec'd by registrar) Registrar

10-12 - 48 Mary W. Holloman  
 (Date rec'd by registrar) Registrar

10-12 - 48 Mary W. Holloman  
 (Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10872  
332

### 1. PLACE OF DEATH:

County Frederick

City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

enroute to Peninsula General Hospital

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Frederick

City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #3 (Salzman Road)  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Ennis, Mr. Thomas J.

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Etta Ennis

6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) June 3-1873

8. AGE: Years 75 Months 4 Days 22 hrs. min.

9. Birthplace Frederick, Co. Md.  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business William Ennis

12. Name Wm. C. Md.

13. Birthplace Frederick, Co. Md.

14. Maiden name Lucy Murphy

15. Birthplace Frederick, Co. Md.

16. Informant Mr. Ernest E. Ennis

Address R.D. #3, Salisbury Md.

17. Burial Date thereof Oct. 28-48  
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematorium Parsonage

Location Salisbury Md.

18. Funeral director Holloway Co. Walter R. Holloway

Address Salisbury Md.

19. Date rec'd by registrar Oct-27-48

Registrar Loise Strong Taylor

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 19 48 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I signed a death certificate

Immediate cause of death Cerebral occlusion

Due to chronic myocarditis

Due to arteriosclerosis

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lo Rademacher M.D.

Address Salisbury Md. Date signed 10/25/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 29 1948  
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

10873

1. PLACE OF DEATH: *Wicomico*  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *37 mos*  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*MD* County.....*Wicomico*  
 City or town.....*Helena*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Rosa Gertrude Fockey*

## 3. (b) Social Security Number

4. Sex.....*F.* 5. Color or race.....*W.* 6.(a) Single, married, widowed, or divorced.....*Widow*  
 6.(b) Name of husband or wife.....*Isaac Fockey*  
 7. Birth date of deceased (mo., day, yr.).....*Sept 3, 1859* 6.(c) If alive, give age..... years

8. AGE: Years.....*89* Months.....*10* Days.....*10* If less than one day.....hrs. ....min.

9. Birthplace.....*Salisbury, Wicomico, Md.*  
 (Town, county, and state)

10. Usual occupation.....*Housewife*

## 11. Industry or business

12. Name.....*Spicer Smith*

13. Birthplace.....*unknown*

14. Maiden name.....*Sarah Fitchens*

15. Birthplace.....*unknown*

16. Informant.....*Mrs. Alice Farmer*

Address.....*Helena Md.*

17. Burial, cremation, or removal, Which?.....*Burial* Date thereof.....*10/15/48*  
 (month) (day) (year)

Cemetery or crematory.....*Helena Md.*

Location.....*Helena Cemetery*

18. Funeral director.....*David E. Merrick*

Address.....*Helena Md.*

19. *10-15-* 19 *48* *Marj W. Hollonay*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*October 13, 1948* at.....*11:50* AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*January 2, 1948* to.....*October 12, 1948*  
 and that I last saw him alive on.....*October 12, 1948*

Immediate cause of death.....*chronic myocarditis*

Due to.....

Due to.....

Due to.....

Due to.....

Other conditions.....*arteriosclerosis*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....*William E. Merrick*

Address.....*Helena Md.* M. D. or other.....*Oct. 14 - 48*

Date signed.....

CERTIFICATE OF DEATH

STATE OF NEW YORK

MEDICAL CERTIFICATE

RECEIVED  
OCT 16 1948  
BUREAU A. B.

RECEIVED  
OCT 18 1948  
BUREAU A. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10874

Reg. Dist. No. 332

1. PLACE OF DEATH: *Wicomico*  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
*Parsonage street*  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....*Md*.....County.....*Wicomico*  
City or town.....*Fruitland*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *Parsonage street*  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME

*Minnie H. Goslee*

3. (b) Social Security Number

4. Sex.....*female*.....5. Color or race.....*White*.....6. (a) Single, married, widowed, or divorced.....*Widow*

6. (b) Name of husband or wife.....*Charles L. Goslee*

7. Birth date of deceased (mo., day, yr.).....*Sept. 1st 1873*.....6. (c) If alive, give age.....*Dead*.....years

8. AGE: Years.....*75*.....Months.....*1*.....Days.....*26*.....If less than one day.....hrs.....min.

9. Birthplace.....*Eden Maryland*  
(Town, county, and state)

10. Usual occupation.....*House wife*

11. Industry or business.....*at home*

12. Name.....*Henry Pusey*

13. Birthplace.....*Eden Maryland*

14. Maiden name.....*Sallie Merensh*

15. Birthplace.....*Eden Maryland*

16. Informant.....*Mr. Boyd Goslee*

Address.....*128 N. Carol Blvd, Upper Darby Pa.*

17. *Burial*.....Date thereof.....*Oct 30-48*  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....*Fruitland Cemetery*

Location.....*Fruitland Maryland*

Funeral director.....*Holloman & Co. Hattah. Holloman*

Signature.....*Sallie Merensh*

19. *Oct-28*.....19*48*.....*Loisethorngayle*  
(Date rec'd by Registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Oct. 27th*.....19*48*.....at.....*3:45a*.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*7-1-48*.....19.....to.....*10-27*.....19.....*48*

and that I last saw him.....*alive*.....on.....*10-27-48*.....19.....

Immediate cause of death.....*Cerebral Hemorrhage*.....DURATION.....*1 month*

Due to.....*Syphilis*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Manner of injury.....Injured at work?

Signature.....*L. L. Pusey M.D.*

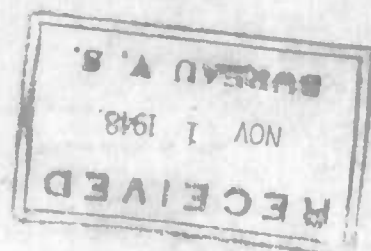
Address.....*Fruitland Md*.....Date signed.....*10-28*

19.....

VS A15 9:45:15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

159

10875

332

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Wicomico (Residence)  
Delmar (Md.)

City or town Delmar  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Hastings Baby Girl Lois ANN

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_

B. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 9-29-48

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Salisbury, Wicomico, Md  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Gardner Hastings13. Birthplace Md14. Maiden name ELLEN Aline Lewis15. Birthplace Md.16. Informant Mr. Gardner HastingsAddress Delmar, Md.

17. Buried Date thereof 10-2-48  
 (Burial, cremation, or removal, whichever) (month) (day) (year)

Cemetery or crematory H. P. CemeteryLocation Delmar Del.18. Funeral director W.S. Marvel Co.Address Delmar, Del.

19. October 2 19 48 Louise Strong Taylor  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 19 48 at 1125 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 19 48 to Oct 1 19 48  
 and that I last saw him alive on Oct 1 19 48

Immediate cause of death Pneumonia Bunch  
(7 mos)

DURATION

Due to \_\_\_\_\_

Due to Mother had 2 pneumonia  
leap 101 at time of delivery

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

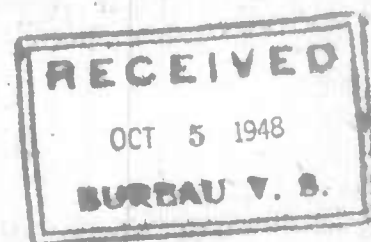
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John R. Mann  
Salisbury Md M. D. or other 10/2/48  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10876

Reg. Dist. No. 332

### 1. PLACE OF DEATH

County Wicomico  
City or town Summitland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD. County Wicomico  
City or town Summitland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Ellen A. Hayman

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife James Arthur Hayman

7. Birth date of deceased (mo., day, yr.) April 6 - 1879

8. AGE: Years 74 Months 6 Days 2 If less than one day \_\_\_\_\_

9. Birthplace Anne Arundle Co. Md.  
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business at home

12. Name Thomas W. Hower

13. Birthplace Anne Arundle Md.

14. Maiden name Anna Schekelle

15. Birthplace Anne Arundle Co. Md.

16. Informant Miss Florence Hayman

Address Fruitland Maryland

17. Burial, cremation, or disposal Buried Date thereof 10-10-48  
(month) (day) (year)

Cemetery or crematory St. John's R. C. Ch.

Location Fruitland Md.

18. Funeral director Walter R. Adams

Address Salisbury Md.

19. 10-9 19 48 Mary W. Holloway  
(Date rec'd by registrar) per Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8<sup>th</sup> 19 48 at 11 a.m.

I CERTIFY that death occurred on the date above stated; that I attended deceased from 7:20 a.m. 1948 to Oct 8 1948 and that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Pneumonia DURATION 5 min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Terminal Pneumonia  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

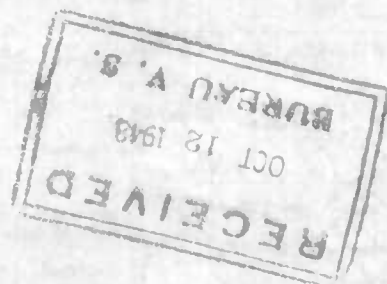
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Lu L. Lawry M.D.  
Address Fruitland Md. Date signed 10-8-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

10877

Reg. Dist. No. 332

1. PLACE OF DEATH *McCombs*  
County *Willards*  
City or town *Willards*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED  
(For non-transients give residence of mother)  
State *Md.* County *McCombs*  
City or town *Willards*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME *Charles Albert Heam*

3. (b) Social Security Number

4. Sex *Male* 5. Color of face *White* 6. (a) Single, married, widowed, or divorced *married*  
6. (b) Name of husband or wife *Margaret Jane Heam*  
8. (c) If alive, give age *48* years  
7. Birth data of deceased (mo., day, yr.) *June 14-1884*  
8. AGE: Years *64* Months *4* Days *2* If less than one day min.  
*Willards Md.*

9. Birthplace *Chapin*  
10. Usual occupation  
11. Industry or business  
12. Name *Charles Roger Heam*  
13. Birthplace *Willards Md.*  
14. Maiden name *May L. Dennis*  
15. Birthplace *Willards Md.*

16. Informant *Mr. Margaret J. Heam*  
Address *Willards Maryland*  
17. *Buried* Date thereof *Oct. 19-1948*  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory *Willards Cemetery*  
Location *Willards Maryland*  
18. Funeral director *William H. Halliday*  
Address *Salisbury Maryland*

19. *October 19 1948* Registrar *Louise Strong Taylor*  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 16th* 19 *48* at *6:15 p*  
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *April* 19 *45* to *day of death*  
and that I last saw him alive on *Oct 16, 1948*

Immediate cause of death *Coronary occlusion*  
*myocarditis - heart block*  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury (Injured at work?)

23. SIGNATURE *Frank Lewis M.D.*  
Address *Willards Md.* Date signed *Oct 18 1948*

## DURATION

*1.8 minutes*  
*3 yrs.*

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD FORM NO. 100

RECEIVED

OCT 21 1948

BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:  
 County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
215 New York Ave  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For new-born infants give residence of mother)  
 State MD County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 215 New York Ave  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

3. (a) FULL NAME Hilary S. Heam

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Hattie Heam  
 6. (c) If alive, give age 63 years  
 7. Birth date of deceased (mo., day, yr.) March 9-1883  
 8. AGE: Years 65 Months 7 Days 2 If less than one day hrs. min.

9. Birthplace Delmar Delaware  
 (Town, county, and state)  
 10. Usual occupation Chapman at  
 11. Industry or business Soap Company  
 12. Name of father Samuel Heam  
 13. Birthplace Sussex County Delaware  
 14. Maiden name Anna Phillips  
 15. Birthplace Sussex County Delaware

16. Informant Mrs. Hattie Heam  
 Address 215 New York Ave. Salisbury Md  
 17. Burial Date thereof Oct. 13-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Parson Cemetery  
 Location Salisbury Maryland  
 18. Funeral director Stellman & Co. Baltimore  
 Address Salisbury Md

19. 10-13 19 48 James W. Holloway  
 (Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11<sup>th</sup> 48  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 47 to Oct 11 19 48  
 and that I last saw him alive on Oct 10 19 48  
 Immediate cause of death

Carcinoma of Stomach  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

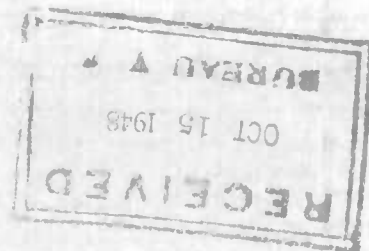
22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Leroy R. France M.D.  
 Address Salisbury Md Date signed 10/14/48  
 M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 331

### 1. PLACE OF DEATH:

County McCombs  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
1701 N. Division st.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)  
State MD County McCombs  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1701 N. Division st.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Lola B. Heaster

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Cloumie J. Heaster

7. Birth date of deceased (mo., day, yr.) March 6-1878 6. (c) If alive, give age 77 years

8. AGE: Years 70 Months 7 Days 1 If less than one day  
hrs. min.

9. Birthplace Camden - on - Bailey, N. Va.  
(Town, county, and state)

10. Usual occupation House wife at home

11. Industry or business

12. Name Charles Ryan

13. Birthplace Camden - on - Bailey, N. Va.

14. Maiden name Emeline J. Morton

15. Birthplace Camden - on - Bailey, N. Va.

16. Informant M. Cloumie J. Heaster

Address 1701 N. Division st. Salisbury Md

17. Burial Date thereof Oct. 10-48  
(Burial, cremation, or reposal, Which?) (month) (day) (year)  
Cemetery or crematory Parson Cemetery  
Location Salisbury Md  
18. Funeral director Holloman & Co. Walter R. Holloman  
Address Salisbury Md

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1948, at 10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to Oct 7 1948  
and that I last saw him alive on Oct 7 1948

Immediate cause of death Carcinoma lung

Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Date of

Where did injury occur?  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Philip A. Lusk M. D. or other  
Address Salisbury Md Date signed 10-5-48

19. 10-9-48 19. Manly W. Holloman  
(Date rec'd by registrar) Deputy Registrar

10879

47a

331

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



VS A15

9-45-15A

MARGIN RESERVED FOR BINDING

1

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 330

10880

112

### 1. PLACE OF DEATH:

County Wicomico  
City or town Mardela  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo.

Hospital, institution, or street address where death occurred:  
Mardela, Md

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico

City or town Mardela  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Mardela  
(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (a) FULL NAME

Samuel George Leonard Nitch Jr.

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Emma B Nitch

7. Birth date of deceased (mo., day, yr.) Sept 2, 1877 6. (c) If alive, give age 69 years

8. AGE: Years 74 Months 1 Days 7 If less than one day  
hrs. min.

9. Birthplace Salisbury, Wicomico, Md  
(Town, county, and state)

10. Usual occupation Realtor

11. Industry or business

12. Name Samuel George Leonard Nitch

13. Birthplace Salisbury, Md

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs Samuel Nitch

Address Mardela, Md

17. Burial Date thereof 10/11/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mardela

Location Mardela, Md

18. Funeral director The Well Johnson Co

Address Salisbury, Md

19. 10-11-48 W.H. Robertson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
One week 1948, to 19  
and that I last saw h. alive on dead when seen 1948

Immediate cause of death

Heart failure

Due to asthma - for five yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

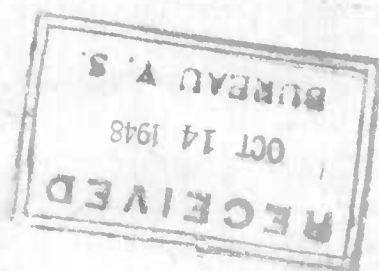
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.H. Robertson M. D. or other

Address Mardela, Md Date signed 10/11/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

10881

93d

### 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 weeks  
Hospital, institution, or street address where death occurred:  
415 Davis Street  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
City or town Ewell (Smiths Island)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If referen. name war. \_\_\_\_\_

### 3. (a) FULL NAME

MATILDA E. JOHNSON

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Joseph Johnson

7. Birth date of deceased (mo., day, yr.) July 22, 1861 8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 87 Months 2 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Smiths Island-Somerset-Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Job Evans

13. Birthplace Smiths Island

14. Maiden name Elizabeth Mills

15. Birthplace Dorchester County, Md.

16. Informant Elwood Johnson

Address Princess Anne, Maryland

17. Burial Date thereof Oct. 24, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rhodes Point Cemetery

Location Rhodes Point, Maryland

18. Funeral director H. Harvey Bradshaw

Address Crisfield, Maryland

19. Oct-29 1948 Louise Strong Taylor  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1948 at 4:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ to \_\_\_\_\_

and that I last saw him alive on Oct. 18 1948

Immediate cause of death Myocardial Insufficiency DURATION 2 yrs

Due to Arteriosclerotic Heart Disease 5 yrs

Due to Arteriosclerosis

Other conditions Trophic ulcers - legs

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature David Gikure MD

Signature Chickie

Signature Oct. 22 1948

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

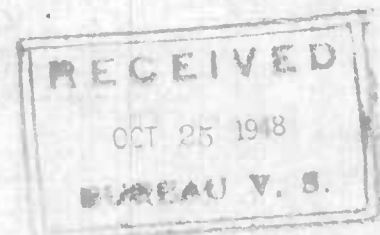
Signature \_\_\_\_\_

Signature \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change in spelling of surname shown on:

MD No. G 117 OCT 29 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10882

332

1. PLACE OF DEATH:

County..... **Wicomico**  
City or town..... **Salisbury**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

**6 weeks**

Hospital, institution, or street address where death occurred:

**peninsula General Hospital**

How long in hospital or institution?

3. (a) FULL NAME

(Kirwan)

**Julia Kirwan**

4. Sex

**female**

5. Color or race

**white**

6. (a) Single, married, widowed, or divorced

**widowed**

6. (b) Name of husband or wife

**John L. Kirwan**

7. Birth date of deceased (mo., day, yr.)

**Feb. 18, 1864**

8. AGE:

**84**

Years

Months

**9**

Days

**2**

It less than one day

hrs.

min.

9. Birthplace

**Mt. Vernon, Somerset Co. Md**

(Town, county, and state)

10. Usual occupation

**At home**

11. Industry or business

MOTHER FATHER

12. Name

**O. W. Furniss**

13. Birthplace

**Maryland**

14. Maiden name

**Arzula Vetra**

15. Birthplace

**Maryland**

16. Informant

**Mrs. Charles Bounds**

Address

**Mt. Vernon, Maryland**

17.

**Burial**

Date thereof

**Oct. 24, 1948**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

**John Wesley Cemetery**

Location

**Mt. Vernon, Maryland**

19. Funeral director

**Wilson Funeral Home**

Address

**Princess Anne, Md.**

19.

(Date rec'd by registrar)

**October 23, 1948**  
**Lois Strong Taylor**  
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

**Md.**

County.....

**Somerset**

City or town.....

**Mount Vernon**

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Oct. 22, 1948** ..... 19..... at **7:40 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**Sept. 7** ..... 19..... **Oct. 22** ..... 19.....  
and that I last saw him alive on **Oct. 22** ..... 19.....

Immediate cause of death

**Primary Carcinoma of Lung**

DURATION

**4 months**

Due to.....

Due to.....

Other conditions

**Arterio Sclerosis**  
**Extreme Undernutrition**

(Include pregnancy within 3 months of death)

Major findings at operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

**David H. Taylor M.D.**  
**Salisbury, Md.**  
Date signed **Oct. 23, 1948**

This deceased's name should be =

Kirwan (not Kinwan)

corrected by daughter -

Mrs. Chas. Bounds of  
Th. Anne, Md.

S.S. Taylor, R.P.C.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH  
 County Wicomico  
 City or town Quantico  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State MD County Wicomico  
 City or town Quantico  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
Oscar Lawrence

3. (b) Social Security Number

4. Sex M. 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Julia Lawrence  
 6. (c) If alive, give age 59 years  
 7. Birth date of deceased (mo., day, yr.) October 25, 1883

8. AGE: Years 65 Months 5 Days — If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Georgetown, Sussex, Del.  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name Mary William

15. Birthplace Georgetown Del.

16. Informant Julia Lawrence

Address Quantico Md.

17. Burial Date thereof 10/28/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Quantico Cemetery

Location Quantico Md.

18. Funeral director Said K. Sherrick

Address Belton Md.

19. Oct. 28 48 Loisae Thompson Taylor  
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/48 1948 at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 October 1948 to 25 October 1948 and that I last saw him alive on 25 October 1948

Immediate cause of death Cardiac Failure DURATION 2 weeks

Due to Arteriosclerosis  
Heart Disease

Due to Heart Disease

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

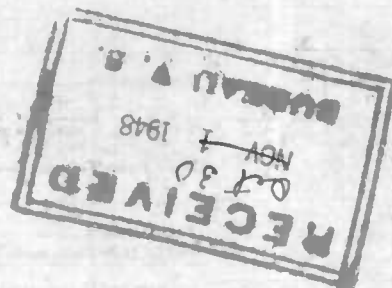
23. SIGNATURE Richard H. Saunders M.D.  
 M. D. or other

Address Quantico Md. Date signed 27 Oct 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





Evidence for change of  
birth date shown on:

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 11

TUL No. 6-110 NOV 24 1948

## 1. PLACE OF DEATH:

County WicomicoCity or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred

418 State Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)Street No. 418 State Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Willard Washington Le Cates

## 3. (b) Social Security Number

None4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Olevis Le Cates6. (c) If alive, give age 85 years7. Birth date of deceased (mo., day, yr.) May 28, 18638. AGE: Years 89 Months 4 Days 6 If less than one day

hrs. min.

9. Birthplace Sussex County, Del.  
(Town, county, and state)10. Usual occupation Retired Farmer11. Industry or business Farm12. Name John Le Cates13. Birthplace Sussex County, Del.14. Maiden name Mary Baker15. Birthplace Sussex County, Del.16. Informant W. O. Olevis Le CatesAddress Delmar, Delaware17. Burial Buried Date thereof Oct. 6, 1948  
(month) (day) (year)Cemetery or crematory Smith MillsLocation Delmar, Del. R. 21018. Funeral director H. S. Marvel Co.Address Delmar, Delaware19. October 5th 1948 Harry E. Hudson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1948 at 8:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1948 to Oct 4, 1948and that I last saw him alive on Oct 4, 1948Immediate cause of death Hemorrhage frombladder & prostate glandDue to Carcinoma of ProstateGland & Bladder

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

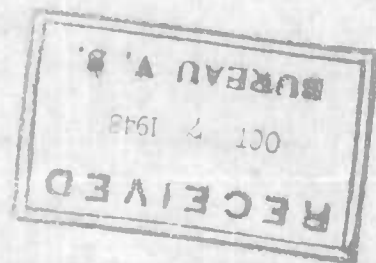
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Hudson M. D. or otherAddress Delmar, Del. Date signed Oct 5, 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newly born infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Year

Months

Day

If less than one day

...hr.

...min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH

10

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D.

Address

Date signed

RECEIVED

OCT 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age and birthdate shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE No. G 117 NOV 9 1948 CERTIFICATE OF DEATH

Reg. Dist. No.

10886

335

1. PLACE OF DEATH:

County... Wilcomico  
City or town... Sharptown md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? life  
Hospital, institution, or street address where death occurred: no  
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... Wilcomico  
City or town... Sharptown md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... no  
(If rural, give LOCATION) no  
2(a) If veteran, name war... no

3. (a) FULL NAME

George Mc Glatte  
4. Sex... male 5. Color or race... a. a. 6. (a) Single, married, widowed, or divorced... married  
6. (b) Name of husband or wife... Mary Mc Glatte  
7. Birth date of deceased (mo., day, yr.)... about 1844 1870  
8. AGE: Years... 68 78 Months... Days... If less than one day... hrs. min.

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

2D. DATE OF DEATH... 10 23 19 48 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about 19 to 19 and that I last saw him alive on 10/25/48

Immediate cause of death... coronary occlusion

Due to... myocarditis - chronic

Due to... arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op.

Autopsy results... not

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No  
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... John P. Stewart M. D. or other

Address... Sharptown md Date signed... 10/25/48

9. Birthplace... Sharptown (Town, county, and state)  
10. Usual occupation... laborer  
11. Industry or business... same as above  
12. Name... James Mc Glatte  
13. Birthplace... Sharptown md  
14. Maiden name... Harriet Gains  
15. Birthplace... Sharptown md  
16. Informant... Harriet Gains  
Address... Sharptown md  
17. Burial Date thereof... Oct 26 - 48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory... Zion  
Location... Sharptown md  
18. Funeral director... James P. Stewart  
Address... md  
19. 10-28 19 4 Walter G. Mann  
(Date rec'd by registrar) Registrar

DURATION  
2 years  
devent  
3 yrs





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

10887

181

## 1. PLACE OF DEATH

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Baker Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. Baker St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Andrew M. McMillan

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan. 29. 1869

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

79814

hrs.

min.

## 9. Birthplace

Philadelphia Pa.  
(Town, county, and state)

## 10. Usual occupation

Shut Metal Worker

## 11. Industry or business

MOTHER FATHER

12. Name

Andrew McMillan

13. Birthplace

Philadelphia Pa.

14. Maiden name

Rosetta Vanley

15. Birthplace

Ireland

## 16. Informant

M. Charles E. McMillan

Address

417. Walnut St. Darty Pa.

17.

(Burial, cremation, or removal, Which)

Date thereof

Oct. 13-48  
(month) (day) (year)

Cemetery or crematory

Oakland Cem.

Location

Philadelphia Pa.

## 18. Funeral director

William L. Waller R. Hollaway

Address

Salisbury Maryland.

19.

(Date rec'd by registrar)

10-14-48  
Mary W. Hollaway  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 13<sup>th</sup>1948 at 245p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

medical 1948 to certificates 1948

and that I last saw h.....

Immediate cause of death

Asphyxiation

DURATION

Sudden  
Death

Due to.....

Due to.....

Other conditions

Burns of body

(Include pregnancy within 3 months of death)

Major findings of operations

noneSudden  
Death

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident

Date of

Oct 13, 1948

Where did injury occur?

Salisbury  
(City or town)Wicomico  
(County)MD  
(State)

Injured at home, farm, industry, public place (where?)

Means of injury

oil stove  
exploded

Injured at work?

No

23. SIGNATURE

W. R. Hollaway  
RegistrarM. P.

M. D. or other

Address

Salisbury Md

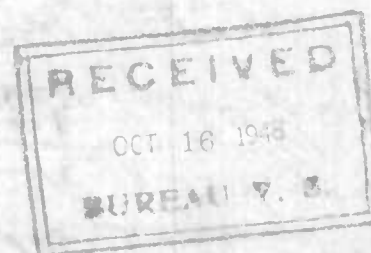
Date signed

10/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Include exact age is especially important. Physicians: please write the causes of death clearly and legibly



... 1A/17/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10889

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Near Pittsville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 65 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Wicomico  
 City or town Near Pittsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Edna Alice Parsons

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

May 24<sup>th</sup> 1883

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

6568

hrs.

min.

## 9. Birthplace

Near Pittsville Md

(Town, county, and state)

## 10. Usual occupation

House work

## 11. Industry or business

Geo. Cyrus Parsons

## FATHER

## 12. Name

Near Pittsville Md

## 13. Birthplace

## 14. Maiden name

Ann Elizabeth Wells

## 15. Birthplace

Near Pittsville Md

## 16. Informant

Fred Parsons

## Address

R.F.D. Pittsville Md

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Oct 3 - 1948

(month) (day) (year)

## Cemetery or crematory

Parsonsburg, Md.

## Location

Parsonsburg, Md.

## 18. Funeral director

Wm. Howard Vrees

## Address

Pittsville, Md.

## 19. Oct - 3

(Date rec'd by registrar)

19 48Louise Strong Taylor

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Oct 2nd 19 48 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 Sept 48 to 2 Oct 48and that I last saw or alive on 2 Oct. 19 48

Immediate cause of death

Starvation  
Self imposed - psychosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. E. Bolton, M.D.  
Pittsville Md. M. D. or other  
Address..... Date signed 3 Oct 48

## DURATION

3 mos.

RECEIVED

OCT 5 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County Wilcomico  
 City or town Salisbury Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 1/2 years  
 Hospital, institution, or street address where death occurred  
Penninsula General Hospital  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Wilcomico  
 City or town Salisbury Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 100  
 (If rural, give LOCATION) no  
 2(a) If veteran, name war no

## 3. (a) FULL NAME

McKendry Piper

## 3. (b) Social Security Number

117-10-8288

4. Sex male 5. Color or race aa 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mary Piper  
yes 6. (c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) about 1883

8. AGE: Years 65 Months 5 Days 1 If less than one day hrs. min.

9. Birthplace Salley S. C.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Same as above

12. Name General Piper

13. Birthplace S.C. Aiken Ga

14. Maiden name Lucie Praxwell

15. Birthplace S.C. Aiken Ga

16. Informant Rosa Sanders  
 Address Wagner S.C. R.R. No 1

17. Burial Date thereof from 3-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Cem.

Location Salley S.C.

18. Funeral director James H. Stewart

Address Salisbury Md

19. October 28 1948 Registrar Lois Strong Taylor  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 24<sup>th</sup> 1948 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/24 1948 to 10/24 1948

and that I last saw him alive on October 24 1948

Immediate cause of death Coronary Nerve Damage DURATION 3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

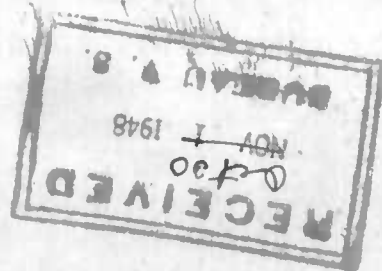
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Oliver F. Fisher, M.D. M. D. or other

Address Salisbury Md Date signed 10/27/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County Wilkes  
 City or town Salisbury 1012 Lake St.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Leah Jane Poulson

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife John Thomas Poulson

7. Birth date of deceased (mo., day, yr.) March 23<sup>rd</sup> 1865 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 83 Months 7 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Accomack County, Va  
 (Town, county, and state)

10. Usual occupation Domestic11. Industry or business Home12. Name Do not know

13. Birthplace \_\_\_\_\_

14. Maiden name Bethu Allen15. Birthplace Acco. Co, Va16. Informant Mrs. Annie WebbAddress 1012 Lake St., Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof October 13, 1948  
 (month) (day) (year)

Cemetery or crematory Burtons - VirginiaLocation Wachapreague, Va18. Funeral director J. Edgar ThomasAddress Accomack, Virginia19. October 19, 1948 Lois Strong Taylor Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Accomack

City or town Smells  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 11<sup>th</sup> 1948 at 4:55 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1948 to Oct 11, 1948

and that I last saw him alive on Sept 10, 1948

Immediate cause of death \_\_\_\_\_

DURATION

Chronic Hypertension 1 year

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. H. Sembly M.D. M. D. or otherAddress Salisbury, Md Date signed 10/11/48

RECEIVED

OCT 21 1948

BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Doubly)

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

830  
10892  
332  
Reg. Dist. No.

1. PLACE OF DEATH:  
County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Peninsula General Hospital  
How long in hospital or institution? 3 days 18 hrs., 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 908. Riverside Drive  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME  
PRICE - Mrs. Dora

3. (b) Social Security Number

4. Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Walter B. Price

7. Birth date of deceased (mo., day, yr.) May 8 - 1893 6. (c) If alive, give age 56 years

8. AGE: Years 55 Months 5 Days 1 If less than one day hrs. min.

9. Birthplace Summit G. Champ Md.  
(Town, county, and state)

10. Usual occupation Home wife  
at Home

11. Industry or business George Hopkins

12. Name George Hopkins  
13. Birthplace Summit G. Md.

14. Maiden name Catherine Ford  
15. Birthplace Summit G. Md.

16. Informant Walter B. Price  
Address 908. Riverside Drive, Salisbury Md.

17. Burial Oct. 12 - 1948  
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)  
Cemetery or crematory Wicomico Mem. Park  
Location Salisbury Maryland

18. Funeral director Holloman G. Walter R. Hollinger  
Address Salisbury Maryland

19. Oct 12, 1948  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 19 48, at 5:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 4 19 48, to Oct. 10 19 48  
and that I last saw him/her alive on Oct. 10 19 48

Immediate cause of death Cerebral Hemorrhage  
Due to arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

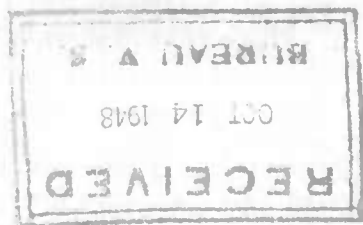
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (State)

Means of injury Injured at work?

23. SIGNATURE Flora A. Insley  
10-12-48  
Registrar





Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10893

332

FILM No. G 117 NOV 8 1948

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

County..... Wicomico

City or town..... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital  
How long in hospital or institution?..... 1 day, 13 hrs., 30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED: 1

(For non-transients give residence of mother)

State..... Md. County..... Wicomico

City or town..... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... R.D. #3  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

RICE (Ernest Augustus Rice)

3. (b) Social Security Number

4. Sex..... M. 5. Color or race..... W. 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Lucia Rosemarie Rice

7. Birth date of deceased (mo., day, yr.)..... Feb. 8-1865

8. AGE: Years..... 83 Months..... 8 Days..... 16 hrs..... min.....

9. Birthplace..... Baltimore Md.  
(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business.....

12. Name..... Samuel Rice

13. Birthplace..... Baltimore Md.

14. Maiden name..... Anna Chapman

15. Birthplace..... Baltimore Md.

16. Informant..... Mrs. Lucia Rice

Address..... R.D. #3, Salisbury Md.

17. Burial, cremation, or removal..... Buried Date thereof..... Oct. 28-48

(Burial, cremation, or removal of which?).....

Cemetery or crematorium..... Peninsula Cemetery

Location..... Salisbury Md.

18. Funeral director..... W. C. Walter R. Hill

Address..... Salisbury Md.

19. Oct-27 19 48 Seimanting Taylor

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 24 19 48 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 22 19 48 to Oct. 24 19 48 and that I last saw him alive on Oct. 24 19 48

Immediate cause of death..... Anteriosclerotic Heart Disease

Due to..... Coronary Artery Anteriosclerosis

Due to..... Semile Dementia

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Injury..... Injured at work?

Signature..... David J. Gilman M.D.

23. SIGNATURE..... Salisbury Md. M. D. or other

Address..... Date signed..... Oct 24 1948

MARGIN RESERVED FOR BINDING

I

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 29 1948  
BUREAU A. S.

Evidence for the change in child's name

shown on film #G117

10/8/48 g.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10894

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 hrs.

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 24 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

(Danny Ray)

Donny Ray Richardson

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

(a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Oct 2 - 1948

8. AGE:

Years

Months

Days

If less than one day

24 hrs.

min.

9. Birthplace

Salisbury, Wicomico Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Willard F. Richardson Jr.

13. Birthplace

Maryland

14. Maiden name

Gloria Mae Twigg

15. Birthplace

Maryland

16. Informant

Willard F. Richardson Jr.

Address

Pocomoke Md.

17. Burial

(Burial, cremation, or inhumation. Which?)

Date thereof

Oct 4 - 1948  
(month) (day) (year)

Cemetery or crematorium

Salix M. E. Cemetery

Location

Pocomoke City, Md.

18. Funeral director

Shirley A. Taylor

Address

Pocomoke City Md.

19. Date rec'd by registrar

October 5 - 1948Lois Strong Taylor  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 3 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct. 2 1948to Oct. 3 1948

and that I last saw him alive on

Oct. 3 1948

Immediate cause of death

Congenital Cardiac Condition

DURATION

24 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_

Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Louis J. Flewellyn MD  
M. D. or other

Address

Pocomoke CityDate signed 10/4/48

MARGIN RESERVED FOR BINDING

VS A15 9/45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully in correct age. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10895 332

## 1. PLACE OF DEATH:

County WilcomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 weeks

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 2 1/2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County DelawareCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. no  
(If rural, give LOCATION)2(a) If veteran, name war no ✓

## 3. (a) FULL NAME

Ellis Robinson

## 3. (b) Social Security Number

214-16-4796

## 4. Sex

male

## 5. Color or race

aa

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Lutile Robinsonyes 6. (c) If alive, give age not know years7. Birth date of deceased (mo., day, yr.) Feb 2 1902

## 8. AGE:

Years 46 Months 8 Days 5 It less than one day hrs. min.9. Birthplace Florence South Carolina  
(Town, county, and state)10. Usual occupation laborer11. Industry or business same as above12. Name George Robinson13. Birthplace Florence S.C.14. Maiden name Ellis Battell15. Birthplace Florence S.C.16. Informant Mrs. Lutile RobinsonAddress Snow Hill Md17. Burial Date thereof Oct 9-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BaptistLocation Snow Hill Md18. Funeral director James H. StewartAddress Salisbury Md19. 10-9- 19 48 W. W. Hollonay  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 19 48 at 8:00 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/20 19 48 to 10/7 19 48and that I last saw him alive on 10/7 19 48Immediate cause of death Reticulum Cell DURATIONSarcoma of abdomen

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations far advancedSarcomatosis Date of op. 10/6/48Autopsy results none permitted

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

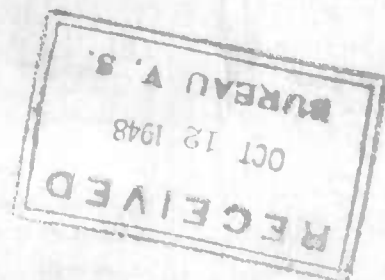
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David B. Gray M. D. or otherAddress Peninsula Gen. Hosp Date signed 10/9/48W. W. Hollonay RegistrarDeputynonononononononononononononono





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

10896

332

Reg. Dist. No. ....

## 1. PLACE OF DEATH

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R. B. Hopt.  
How long in hospital or institution 5 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 204. Wicomico street  
(If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (a) FULL NAME

Smith - Mr. George Henry

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1st 1948 11:50 AM21. I CERTIFY that death occurred on the date above stated; that it attended deceased from September 26 1948 to October 1st 1948  
and that I last saw him alive on October 1st 1948Immediate cause of death Cerebral Hemorrhage  
DURATIONDue to HypertensionDue to arteriosclerosisOther condition Myocarditis  
(Include pregnancy within 8 months of death)

Major findings of autopsies .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury .....

Injured at work?

23. SIGNATURE C. J. Heaman M. D. or otherAddress 203 W. Church Date signed 10/3/486. (b) Name of husband or wife Leonora Smith7. Birth date of deceased (mo., day, yr.) July 12 - 18558. AGE: Years 93 Months 2 Days 19 If less than one day .....9. Birthplace Minerva New York  
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business Wesley Smith12. Name North Creek N.Y.13. Birthplace Mariah Gallagher14. Maiden name Minerva N.Y.15. Birthplace Mr. Margaret M. J. Smith16. Informant Stony Creek, New York17. Address Oct. 16 - 194818. Date of death Oct. 16 - 194819. (Burial, cremation, or removal. Which?) St. Philip Cemetery20. Cemetery or crematory Knowell Hunt N.Y.21. Location Holloman & Co. Walter R. Holloman22. Funeral director Salisbury Maryland23. Address Oct-3 1948 Salisbury Maryland  
(Date rec'd by registrar)

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

OCT 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? one month 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Westover  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles Somers

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color of

white

## 6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Sallie E. Somers

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 18708. AGE: Years Months Days If less than one day  
77 10 9 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Fairmount, Somerset Co. Maryland  
(Town, county, and state)  
Carpenter

## 10. Usual occupation

## 11. Industry or business

12. Name George Somers13. Birthplace Somerset Co. Maryland14. Maiden name Drucilla Townsend15. Birthplace Maryland16. Informant Mr. Paul SomersAddress Westover, Maryland17. Burial Date thereof Oct. 28, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Andrew CemeteryLocation Princess Anne, Maryland  
Wilson Funeral Home18. Funeral director Princess Anne, Maryland

Address \_\_\_\_\_

19. Oct-28-48 Lois Armstrong Taylor  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948 10:50p21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23 1948 to Oct. 25 1948  
and that I last saw him alive on Oct. 25 1948

Immediate cause of death

Myocardial Insufficiency 2 weeks  
Coronary Artery Thrombosis 3 weeks

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Nephrosclerosis  
Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

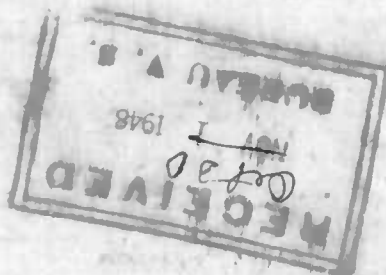
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE David H. Moore M.D.Address Salisbury, Md. Date signed Oct. 28, 1948

3 L.C. 1 G.C.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

932

10898

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? one week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 408 Borden St

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Tolson, Robert Jones

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male col married6. (b) Name of husband or wife Cecil Tolsonyes 6. (c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) (?) 19408. AGE: Years 48 Months Days If less than one day  
..... hrs. .... min.9. Birthplace Harrisburg, Pa.  
(Town, county, and state)10. Usual occupation Police11. Industry or business Same as above12. Name Samuel S. Jones13. Birthplace Harrisburg, Pa.14. Maiden name Josephine Tolson Jones15. Birthplace Harrisburg, Pa.16. Informant Joseph JonesAddress Washington D.C.17. Burial Date thereof Oct 17 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HoustonLocation Salisbury Md18. Funeral director James H. StewartAddress Salisbury Md19. Oct-18 19 48 Samuel H. Taylor  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 19 48 at 1:45 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/11 19 48 to 10/11 19 48and that I last saw him alive on 10/10 19 48Immediate cause of death myocarditis

## DURATION

several

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results myocarditis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Tolson James H. Stewart

M. D. or other

Address Salisbury Md Date signed 10/24/48

**RECEIVED**

OCT 21 1948

**BUREAU V. S.**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

10899

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. Life Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Waller, George

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

colored

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

August 31, 1933

8. AGE:

Years

Months

Days

If less than one day

15 yrs

hrs.

min.

9. Birthplace

Salisbury Maryland  
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

School

MOTHER

FATHER

12. Name

Harrison Waller

13. Birthplace

Mardella Springs, Md.

14. Maiden name

Lillie Horsey

15. Birthplace

Mardella Springs, Md.

16. Informant

Harrison Waller

Address

Salisbury Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct 4, 1948  
(month) (day) (year)

Cemetery or crematory

Mardella Springs Cem.

Location

Mardella Springs, Md.

18. Funeral director

Herbert M. Bollard Jr.

Address

Cambridge Md.19. Oct 419 48

(Date rec'd by registrar)

Lois Strong Taylor

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 19 48 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug - 8 19 48 to Oct 1 19 48and that I last saw him alive on Sept - 28 19 48

Immediate cause of death

Tf. Meningitis

DURATION

2 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results not reported yet

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James R Mann

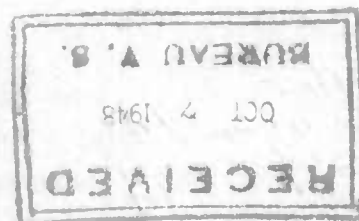
M. D. or other

Address

Salisbury Md

Date signed

10/2/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 11

10900  
336  
11

### 1. PLACE OF DEATH:

County Monroe  
City or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 mo.  
Hospital, institution, or street address where death occurred:  
Chestnut St.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Pennsylvania County Philadelphia  
City or town Philadelphia  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2124 E. Daughlin  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

Gravelle Davis Webster

### 3. (b) Social Security Number

164-09-2506

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Margaret Webster

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1883 6.(c) If alive, give age, years

8. AGE: Years 65 Months 6 Days 1 If less than one day

9. Birthplace Bedfordtown, N.J.  
(Town, county, and state)

10. Usual occupation Shipping Clerk

11. Industry or business Office Fire Insurance Co.

12. Name Gravelle Davis Webster

13. Birthplace Bedfordtown, N.J.

14. Maiden name Sarah Canino

15. Birthplace Bedfordtown, N.J.

16. Informant Mrs. Grace L. Lipp

Address Ocean City, Md.

17. Burial Date thereof Oct 28-1948  
(Burial, cremation, or removal, etc.) (month) (day) (year)

Cemetery or crematory Knights of Pythias

Location Philadelphia, Pa.

18. Funeral director G. S. Samuel Co.

Address Delmar, Del.

October 26, 1948 Harry E. Hudson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25-1948 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11 1948 to Oct 24 1948

and that I last saw him alive on Oct 24 1948

Immediate cause of death Cerebral Hemorrhage DURATION 3 days

1st stroke, at site of aneurysm

Due to Arteriosclerosis 9 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry E. Hudson M. D. or other

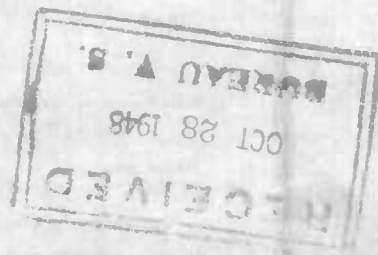
Address Delmar, Pa. Date signed Oct 26-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10901

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County WicomicoCity or town Parramont  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
R.O.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-born infants give residence of mother)

State MD. County WicomicoCity or town Parramont  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.O.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elijah W. Wells

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Fannie Wells7. Birth date of deceased (mo., day, year) Aug. 2<sup>nd</sup> 1871 6.(c) If alive, give age Dead years8. AGE: Years 77 Months 2 Days 15 If less than one day hrs. min.9. Birthplace R.O. Pittsville Md.  
(Town, county, and state)10. Usual occupation Blacksmith11. Industry or business Farm12. Name Fannie Wells13. Birthplace R.O. Pittsville Md.14. Maiden name Mary Parramont15. Birthplace Parramont Md16. Informant Mr. Henry H. WellsAddress 504. Mitchell St. Salisbury Md17. Burial Date thereof Oct. 19-48  
(Burial, cremation, or removal, etc.) (month) (day) (year)Cemetery or crematory Pittsville CemeteryLocation Pittsville Md18. Funeral director William H. G. Galt & SonAddress Salisbury Md19. October 19, 48 Registrar Loise Strong Taylor  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17<sup>th</sup> 194821. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Oct 48 to 16 Oct 48 and that I last saw him alive on 16 Oct 48Immediate cause of death Uremia DURATION Unknown

Due to

Due to

Other conditions Arterio-sclerotic heart disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harold E. Bolton, M.D.Address Pittsville, Md Date signed 18/10/48

RECEIVED

OCT 21 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

10904

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since Sept. 2, 1948

Hospital, institution, or street address where death occurred:

Pine Bluff Sanatorium, Salisbury, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Julia Catherine Wier

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Glendon Wier6. (c) If alive, give age 32 years7. Birth date of deceased (mo., day, yr.) Nov. 28, 19168. AGE: Years Months Days If less than one day  
31 10 9 hrs. min.9. Birthplace Salisbury, Maryland  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name James P. Hinchcliffe13. Birthplace New Jersey14. Maiden name Mary E. Hinchcliffe15. Birthplace Chance, Maryland16. Informant patient on admission

Address

17. Buried Date thereof Oct. 10, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Wicomico Mem. ParkLocation Salisbury, Maryland18. Funeral director Holloman & G. Walter P. HollomanSalisbury, Maryland19. October 7 19 48 Louise Strong Taylor  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 19 48 at 12:05 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2 19 48 to 10/6/48 19 48and that I last saw her alive on 10/6/48 19 48Immediate cause of death Pulmonary Tuberculosis DURATION 7 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M. D. on 10/7/48Address Salisbury, Md. Date signed 10/7/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Michigan

Michigan

Michigan

Since Sept. 2, 1948

RECEIVED

OCT 11 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10902

## 1. PLACE OF DEATH:

County WicomicoCity or town Delmar  
(If outside city or town limits write RURAL and give nearest town)How long in above place of death? 25 yearsHospital, institution, or street address where death occurred:  
State Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)Street No. State  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ernest Willey

## 3. (b) Social Security Number

716-03-16034. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married(b) Name of husband or wife Mrs. Sara Willey7. Birth date of deceased (mo., day, yr.) Sept 11, 1881 6. (c) If alive, age 68 years8. AGE: Years 67 Months 25 Days 25 It less than one day  
hrs. min.9. Birthplace Greenwood, Del.  
(Town, county, and state)10. Usual occupation Retired Seaman11. Industry or business Penn. Railroad Co.12. Name John Willey13. Birthplace Greenwood, Del.14. Maiden name Josephine Johnson15. Birthplace Greenwood, Del.16. Informant Bros. Sara WilleyAddress Delmar, Del.17. Burial Buried Date thereof Oct 9-1948  
(month) (day) (year)Cemetery St. Olive MethodistLocation Delmar, Del.18. Funeral director G. S. Grand Co.Address Delmar, DelawareOctober 9, 1948 Harry E. Hudson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948 at 4:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948 to Oct 6 1948and that I last saw him alive on Oct 6 1948Immediate cause of death Heart coronary  
thrombosis DURATION few minutesDue to Hypertensive Cardiovascular  
disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE St. IgnaceAddress Delmar, DE M. D. or other not  
Date signed Oct 7/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 11 1943

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicomicoCity or town Salisbury, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Booth St  
(If rural, give LOCATION)2.(a) If veteran, name war no

## 3. (a) FULL NAME

Whittington

## 3. (b) Social Security Number

no

4. Sex

male

5. Color or race

col

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

no6. (c) If alive, give age no years

7. Birth date of

deceased (mo., day, yr.)

October 11, 1948

8. AGE:

Years

Months

Days

If less than one day

hrs. 41 min.

9. Birthplace

Peninsula Gen Hospital  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. 10-13-

(Date rec'd by registrar)

19. 48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 19 48 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to 19 48and that I last saw him alive on October 11, 1948

Immediate cause of death

Myocardial infarction

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Salisbury, Md. Date signed 10/11/48

